Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964619	A. BUILDING: _____ B. WING _____	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VILLAGE OF SARASOTA, INC.	8400 VAMO ROAD SARASOTA, FL 34231

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A 000	Initial Comments A relicensure, limited nursing services, emergency power plan monitoring and health facility reporting system survey was conducted at Bay Village of Sarasota, Inc on through . Deficiencies were identified at the time of the survey.	A 000		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his	A 052		

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A 052	Continued From page 1 or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of	A 052		

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A 052	Continued From page 2	A 052		

administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.
(5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.

59A-36.008
(3) ASSISTANCE WITH SELF-ADMINISTRATION.
(a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule.
(b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed.
(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the

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A 052	Continued From page 3 resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure staff who assist with self-administration of medications do so appropriately to orally advise of the names and	A 052		

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A 052	Continued From page 4 doses of the medications being given for 5 (Resident #4, # 5, 12, #13 and #14) of 5 medications observed. The findings included: On at 1:05 p.m., during observation of the Medication pass, Registered Nurse (RN) Staff C provided to Resident #4 , 500 mg (milligrams). Staff C failed to orally advise the names and doses of the medications being given. Review of the Health Assessment Form 1823 dated indicated Resident #4 needed assistance with self-administration of medications. On at 1:07 p.m., during observation of the Medication pass, Registered Nurse (RN) Staff C provided to Resident #5 , 25-100 mg. Staff C failed to orally advise the names and doses of the medications being given. Review of the Health Assessment Form 1823 dated indicated Resident #5 needed assistance with self-administration of medications. On at 1:11 p.m., during observation of the Medication pass, Registered Nurse (RN) Staff C provided to Resident #14 , 300 mg, Staff C failed to orally advise the names and doses of the medications being given. Review of the Health Assessment Form 1823 dated indicated Resident #14 needed assistance with self-administration of medications. On at 9:11 a.m., during observation of the	A 052		

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A 052	Continued From page 5 Medication pass, Registered Nurse (RN) Staff C provided to Resident #12 , 50mg, ER 10 mg, 40 mg, , 40 mg, Preservision AREDS mcg-113, Trelegy , 100 mcg-62.5, , , 42 mcg 6% spray. Staff C failed to orally advise the names and doses of the medications being given. Review of the Health Assessment Form 1823 dated indicated Resident #12 needed assistance with self-administration of medications. On at 9:14 a.m., during observation of the Medication pass, Registered Nurse (RN) Staff C provided to Resident #13 , 120 mg, , 25 mg, , 40 mg, 10 mg, , 10 mg, 40 mg, , 10 mg, ER 10 mg. RN Staff C failed to orally advise the names and doses of the medications being given. Review of the Health Assessment Form 1823 dated indicated 1823 for the Resident #13 needed assistance with self-administration of medications. On at 12:10 p.m., during an interview, Registered Nurse Staff C said when assisting with self administration of medication we typically do not advise residents of the names and dosage unless they ask. Staff C stated the residents do not have medication opt out waivers. On at 2:05 p.m., during an interview, the Assistant Director of Nursing said, when the staff are assisting with self-administration of medications, they are to address the resident and	A 052		

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A 052	Continued From page 6 let them know they are giving the med's, the ADON stated " the staff are only to tell them the names and doses if the resident asks." The ADON acknowledged Staff D did not follow the regulations for assistance with self-administration of medications. Class III .	A 052		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a	A 078		

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A 078	Continued From page 7 written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the facility failed to ensure employees hired	A 078		

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A 078	Continued From page 8 submitted a written statement signed by a healthcare provider indicating freedom from signs and symptoms of communicable 60 days prior to hire or 30 days within hire for 1 (Staff D) of 3 records reviewed. The findings included: Record review for Staff D License Practicing Nurse (LPN) revealed a hire date of . Further review revealed documentation of a Test administred on and read on . There was no evidence of documentation of a statement signed by the healthcare provider indicating freedom from signs and symptoms of communicable on file for Staff D. On at 2:20 p.m., during an interview, the Staff Development Coordinator confirmed there is no statement signed by the healthcare provider indicating freedom from signs and symptoms of communicable is on file for Staff D. Class III .	A 078		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held	A 161		

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A 161	Continued From page 9 by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ˬ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C.	A 161		

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A 161	Continued From page 10 (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to maintain documentation of job descriptions for 1 (Staff D) of 3 records reviewed. The findings included: Record review for Staff D revealed a hire date of as a Licensed Practicing Nurse (LPN). Further review revealed no documentation of a job description on file for Staff D. On at 2:33 p.m., during an interview, the Staff Development Coordinator (SDC) confirmed there was no documentation of a job description on file for Staff D. Class III .	A 161		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance ,	A 162		

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A 162	Continued From page 11 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ◡ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ◡ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ◡ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or	A 162		

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A 162	Continued From page 12	A 162		

administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C.
(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C.
(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S.
(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S.
(l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families.
(m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.
(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C.
(o) The resident's , DH Form 1896, if applicable.

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A 162	Continued From page 13 (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility filed to maintain documentation of the hospice interdisciplinary care plan which delineates and specifies the services being provided by hospice and those being provided by the facility for 3 (Resident #6, #10, #11) of 3 records reviewed for hospice services. The findings included. Record review for Resident #6 revealed an admit date of . Further review revealed Resident #6 was admitted to Affinity Hospice Services on , there was no evidence of documentation of interdisciplinary care plan on file for Resident #6.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964619	A. BUILDING: _____ B. WING _____	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY VILLAGE OF SARASOTA, INC.	8400 VAMO ROAD SARASOTA, FL 34231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 14 Record review for Resident #10 revealed a admit date of . Further review revealed Resident #11 was admitted to Affinity Hospice Services on ., there was no evidence of documentation of interdisciplinary care plan on file for Resident #10. Record review for Resident #11 revealed an admit date of . Further review revealed Resident #11 was admitted to Affinity Hospice Services on , there was no evidence of documentation of interdisciplinary care plan on file for Resident #11. On at 8:00 a.m., a request was made to Registered Nurse (RN) Staff C for documentation of the interdisciplinary care plan for Residents #6, #10 and #11 for review. On 8:15 a.m., during an interview, Staff C said she spoke with her Assistant Director Of Nursing (ADON) and asked for the interdisciplinary care plans and the ADON told her they are reaching out to Affinity hospice for them to fax the care plans over to the facility as they currently do not have them onsite. Review of documents provided by the facility revealed documents consisted of hospice monthly meeting notes for Residents #10 and #11 and the level of care form for Resident #6. There was no documentation of the interdisciplinary care plans provided. On at 12:30 p.m., during an interview, Staff C acknowledged the documents provided were Hospice IDG (Interdisciplinary Group) meeting notes for Hospice and not the interdisciplinary care plan that shows what hospice does for the residents and what the facility does for the	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 162	Continued From page 15 residents. Staff C confirmed there was no documentation of hospice interdisciplinary care plans on file for the hospice Residents #6, #10 and #11. On at 2:18 p.m., during an interview, the ADON acknowledged there is no documentation of interdisciplinary care plans onsite for the Hospice Residents #6, #10 and #11. Class III	A 162		